Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HUMBERTO PALLADINO MD
5959 GATEWAY WEST SUITE 120
EL PASO TX 79925

Carrier's Austin Representative Box
Box Number 19

MFDR Received Date
MARCH 28, 2013

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-13-1930-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[Injured Employee] sustained a work related injury affecting his left lower extremity. He suffered from bony fractures as well as significant soft tissue damage. During his hospitalization I was contacted to assist with the management of his soft tissue injuries. A total of 4 major and 2 minor procedures were required to heal his injury, some of which were performed on a semi-emergent basis to avoid prolonged exposure of vital tissues."

Amount in Dispute: $17,771.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider failed to get preauthorization. The Texas labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 26, 20012 through December 4, 2012	CPT Codes 99255, 12036-59, 1500., 15274, 15002-59, 15273-59, 11960, 97606, 11971, 97006-78, 15002-78, 15002-78, 97606-59-78, 15002-78, 15271-78,15003-78, 15101-78, 97606-78, 15,100-78, 15852	$17,771.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization for certain health care services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 39 – Services denied at the time authorization/recertification was requested.

Issues

1. Did the requestor receive preauthorization for the inpatient hospital services?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(c)(1) the insurance carrier is liable for all reasonable and necessary medical costs relating to healthcare listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this tile; (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care. 28 Texas Administrative Code §134.600(p)(1) requires inpatient hospital admissions, including the principal scheduled procedures and the length of stay obtain preauthorization. The requestor states in his position summary that some of the procedures "were performed on a semi-emergent basis"; however, the requestor did not submit documentation to support the services were emergent per 28 Texas Administrative Code §133.2(a)(4)(A) which defines "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part…"
2. Review of the submitted documentation finds that preauthorization was not obtained for these services; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 3, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.